NH Medicaid Medical Care Advisory Committee (MCAC)
Monday July 11, 2016
1:00 p.m. – 3:00 p.m.
NH Hospital Association
125 Airport Road
Concord, New Hampshire

Meeting Minutes

Member/Alternate Attendees:
Michael Auerbach, Gina Balkus, Jay Couture, Ellen Edgerly, Alex Koutroubas, Michele Merritt, Paula Minnehan, Sarah Morrison, Ken Norton, Cindy Robertson, Chris Rueggeberg, Charles Saia, Mel Spierer, Carolyn Virtue, Michelle Winchester

Member Absent:
Lisa DiMartino, Travis Harker, Earle Kolb, Doug McNutt, Ann Schwartzwalder, Kristine Stoddard

DHHS Staff Attendees:
Mary Brunette, Kelly Cote, Deb Fournier, Ry Perry, Deb Scheetz

Guests:
Lisabritt Solsky, Well Sense. Sarah Mattson Dustin, NH Legal Assistance.

Review/Approval of June 13, 2016 MCAC Minutes
Meeting minutes approval moved by Cindy Robertson with a second by Mike Auerbach. All in favor.

ACT Program Presentation: Dr. Mary Brunette
Dr. Brunette works for Behavioral Health. She reviews ACT Presentation (attachment 1). Mike says he and the Dental Society are available if any input around dental is needed. Dr. Brunette says that currently ACT will help assist clients find assistance around dental knowing the limited Medicaid dental services. Gina mentions there are several home care agencies which are running into clients with severe mental illness – those patients could be eligible for ACT. Being on Medicaid is not a requirement. There are around 700 people enrolled across the state and the goal is to double that number over the next year. What percent has SUD with those numbers? Dr. Brunette doesn't know for sure; but thinks about 1/3 of them. Michele wonders if MIT is included – Jay says that some mental health centers are offering that. Alex wonders if there is a budget for ACT? It is a reimbursable service – considered part of an array of services that mental health services provide. There is not a separate funding. It is mandated under the settlement agreement.

MCAC Topics
Re-Election of Officers and New Members
Alex Koutroubas motions approval for new members (Jay Couture and Richard Royce) with a second by Ken Norton; all in favor. Jay Couture moves for re-appointment of members whose terms are ending this month; all in favor.

By-Law Process Review
Michelle reviews the changes on the by-laws (attachment 2). At this point the Department will be bringing this back and reviewing internally. Michelle suggests including language to clarify as much as possible. The group suggests getting more context before agenda items are presented. That way the members are able to review material and information and be prepared for questions and input. Any member that has any input for the by-laws should send along to Michelle within the next week. Most of this is agreed upon – Michelle and DHHS will look into how to word the change under membership to include dental and other.

Rule Process Review
Michelle reviews the changes to the rules process (attachment 3). Deb Scheetz has concern on Step 7 change that was suggested. She feels it should be worded differently as sometimes things are moving so quickly and there isn't always time for a written response. Michelle thinks that there needs to be some sort of input. Preference for members is written response but sometimes that is just not possible. It needs to be worded that when possible a written response to the MCAC.

Michelle will do a clean-up of both the By-Laws and Rule Process review and get that version out.

DHHS Updates
Federal Medicaid Managed Care Rules
Deb Fournier reviews presentation: NH Medicaid Care Management CMS Final Rule (Attachment 4). Michelle thinks that she will email a list out to the members and find out who wants to create a subcommittee depending on the subject matter within the managed care final rule. There is a lot of work ahead on certain areas within this final rule.

NHHPP Medicaid 1115 Waiver Amendment Overview
Hearing is tomorrow. The waiver includes: Impose a work requirement on NHPPP beneficiaries, provide a citizenship verification process, impose payment for non-emergent use of emergency department provisions around veterans to receive medical service. Cost sharing would be 1 and 2 dollars for standard Medicaid. This will bring in alignment of what we are currently doing. It's not co-pay on everything. Is there a plan for the Department on how medically frail would be managed with SUD when there are exclusions through IMD? Deb says that she will take this back and discuss with the Department.

Rule Review (subcommittee update)
He-M 1301 Medical Assistance Provided by Educational Agencies
Subcommittee was formed and identified a number of questions and issues and everything has been resolved. There is only one question that the Department is still reviewing around a one-on-one aid being paid for if used on school bus. Because final rule process is being done – Michelle asks members if they agree on submitting MCAC. Carolyn moves with a second by Sarah Morrison to have the MCAC submit input.

Other Business:

Review Tasks
- ☐ Department will review by-laws and the suggested changes
- ☐ Michelle will update and clean-up the bylaws and rules and send out new versions
- ☐ Michelle will reach out to members to get subcommittees established for different sections of the final rule
- ☐ Kelly Cote will send out copy of the CMS final rule presentation as an attachment to the minutes.
- ☐ Deb Fournier will take back the question that Michelle Merit had around SUD and exclusions through IMD.

The next meeting will be held on Monday August 8, 2016 at the NH Hospital Association scheduled from 1:00-3:00.

Respectfully submitted,
Kelly Cote, Administrative Assistant

Bureau of Mental Health Services
Department of Health and Human Services
7.14.16 for Med Dirs
ACT: team structure, incl/transition

Assertive Community Treatment

An Evidence-based Practice

EVIDENCE-BASED PRACTICES
KIT
Knowledge Informing Transformation

2. ACT practice principles

- ACT is a service delivery model, not a case management program
- ACT's primary goal is recovery through community treatment and rehabilitation
- ACT is for consumers with the most challenging and persistent problems
- Programs that adhere most closely to the ACT model are more likely to get the best outcomes

2

3. ACT practice principles

ACT is characterized by:

- A team approach
- In vivo services
- A small caseload
- Time-unlimited services
- A shared caseload
- Flexible service delivery
- Fixed point of responsibility
- Crisis management available 24 hours a day, 7 days a week

3

7. Help is provided when it is needed

- Rather than seeing consumers only a few times a month, ACT team members with different types of expertise contact consumers as often as necessary
- Help and support are available 24 hours a day, 7 days a week, 365 days a year, if needed
- Most ACT members will be seen at least several times a week in the community

4

8. Shared caseload

- ACT team members do not have individual caseloads. Instead, the team shares responsibility for consumers in the program
- Each consumer gets to know multiple members of the team. If a team member goes on vacation, gets sick, or leaves the program, consumers know the other team members

5

9. No preset time limits on services

- ACT has no preset limit on how long consumers receive services. Over time, team members may have less contact with consumers, but still remain available for support if it's needed
- Consumers are not discharged from ACT programs because they are "noncompliant" - it is the team's job to engage the consumer. If one strategy doesn't work, try another

6

10. Close attention to consumers' needs

- ACT team members work closely with consumers to develop plans to help them reach their goals
- In daily team meetings, ACT teams review each consumer's progress in reaching those goals. If consumers' needs change or a plan isn't working, the team responds immediately

7

12. ACT provides assistance with...

- Activities of daily living
- Housing
- Family life
- Employment
- Benefits
- Managing finances
- Health care
- Medications
- Co-Occurring disorders integrated treatment (substance use)
- Counseling

8

15. ACT team staffing

A program serving 100 consumers has at least:

- 1 or more full-time psychiatrists
- 2 full-time nurses
- 2 full-time substance-abuse specialists
- 2 full-time employment specialists

Peer specialists:

- Consumers hold team positions (sometimes called peer specialists) or other positions for which they are qualified with full professional status

9

22. ACT Admission Criteria (All 1,2 & 3)

1. DSM-IV-TR Axis 1 psychotic or major mood disorder +/- co-occurring substance use disorder, AND
2. Eligible for CMHC services (due to significant functional impairments and/or intractable severe major symptoms)
3. Has at least 1 of the following due to mental illness:
   - High use of acute psychiatric hospitalization or psychiatric emergency services in past year
   - High risk or recent history of criminal justice involvement in past year
   - Substandard housing, homeless or at risk of homelessness in past year
   - Living in hospital or group home and could move to independent housing if had ACT at time of referral
   - Inability to participate in traditional office based services due to mental illness in past month

10

23. ACT transition criteria (5/12/2016) (all 3)

1. Has not been in the hospital, emergency room or jail/prison due to SMI/SPMI-related behaviors for more than a year, AND
2. Living in stable housing for more than a year, AND
3. During a transition period, demonstrates ability to utilize office-based non-ACT mental health services as needed to maintain stability for past 6 months

11

26. ACT - Materials to help you implement Assertive Community Tx

Tips to implement ACT are in detail in the Toolkit published by SAMHSA on their website:

http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

You can find toolkits for other evidence-based practices as well.

12

DRAFT REVISION – FOR JULY 11, 2016 MCAC MEETING **Attachment 2**

NH Medicaid Medical Care Advisory Committee By Laws

NOTE: All proposed amendments and comments are in blue. Amendments that are additions are underlined. Amendments that are deletions appear as a strike-through. Comments follow the provision commented upon.

All prior by-laws are hereby repealed, and the by-laws contained in this document are approved and adopted by the Medical Care Advisory Committee on ~~**January 11, 2010**~~ **July 11, 2016**.

I. PURPOSE

The New Hampshire Medical Care Advisory Committee (MCAC) is established in accordance with 42 CFR § 431.12 to advise the State Medicaid Director regarding New Hampshire Medicaid policy and planning.

II. ~~RESPONSIBILITIES~~DUTIES OF MEMBERS

1) **Members will** review and recommend proposals for rules, regulations, legislation, waivers, operations and other Medicaid policies, **in accordance with 42 CFR § 431.12.**

2) **In particular, members will review and provide input on:**
   a) **The annual report on managed care provided under 42 CFR § 438.66(e)(3);**
   b) **Marketing materials submitted by managed care entitities, in accordance with 438.104(c);**
   c) **The managed care quality rating system, in accordance with 42 CFR § 438.334(c);**
   d) **The managed care quality strategy, in accordance with 42 CFR § 438.340(c); and**
   e) **The development and update of the Medicaid access monitoring review plan, in accordance with 42 CFR § 447.203(b).**

   Comment: To more clearly reflect and enumerate Federal policy and associated duties of the DHHS in the by-laws.

3) Formulate or help formulate, review, and evaluate policy proposals, ~~**and their**~~ **considering** fiscal, **program,** ~~**impact, as well as potential**~~ **provider,** and recipient impact, **and make recommendations accordingly**.

   Comments:
   1) Suggest edits for clarity.
   2) Recommend discussion on meaning of "formulate or help formulate" policy and amend par. 3 accordingly.
   3) Members would like to see the MCAC do more in the way of "evaluating fiscal impact."

4) Utilize individual expertise to assist the MCAC in proactively recommending changes to policy, administrative rules and legislation, which support the purpose of the Medicaid program.

5) Maintain familiarity with current financial and legal aspects of the Medicaid program.

Comment: Members would like to see more education of MCAC members on the "financial and legal" aspects of Medicaid, particularly now with so many recipients in managed care.

6) Ensure the membership effectively represents all relevant and concerned viewpoints, particularly those of Medicaid ~~consumers~~**recipients**.

Comment: Suggest edit for consistency in terminology.

7) Ensure ongoing communication between the MCAC and ~~those who administer~~ the **administrators of the** Medicaid program.

Comment:
1) Suggested minor editing.
2) Members are interested in assuming responsibilities possibly to be shed by the Governor's Commission on Medicaid Care Management and recommend a discussion on this point. The discussion should assess:
a) Interest on the part of MCAC members generally;
b) Establishment of a subcommittee to work through detailed recommendations for the larger group to consider; and
c) Consideration as to whether the MCAC should maintain a role in managed care policy regardless of a separate and continued undertaking by the Governor's Commission, should the Commission continue.

III. OPERATING PROCEDURES

1) Meetings:
(a) The MCAC shall operate according to the State fiscal year, which runs from July 1st to June 30th of each year.
(b) The Chair may solicit agenda items from the members in advance of a meeting and will establish agendas in collaboration with the NH Medicaid Director.
(c) One-third of the current MCAC membership shall constitute a quorum for the purpose of doing business
(d) The MCAC will meet as a full committee **monthly** ~~4 times per fiscal year~~. Additional meetings will take place at the call of the chair or upon request of 3 or more members.
Comment: Amend par. (d) to reflect actual practice.
(e) Meeting dates, schedules and location may be changed with notice, at the discretion of the MCAC chair. **In the event such change is made on the day of a scheduled meeting, email notice will be sent to members by administrative staff no later than 9:00 am the day of the meeting, followed by notifications by phone.**
Comment: Amend par. (e) to reflect recent discussion at June MCAC meeting.
(f) Meeting agendas and supporting documents will be sent to members **2 weeks in advance of the meeting.**
Comment: Bolded and underlined text noted as particularly important and should be maintained.

(g) Items may be added to the agenda on the day of the meeting, as time allows, if approved **by a majority of the members present**.
Comment: Bolded and underlined text noted as particularly important and should be maintained.
(h) Action on agenda items may be taken by no less than the majority of members present at the meeting.

2) The MCAC may establish procedures to allow members to participate in meetings by videoconference or speakerphone, and allow for decisions to be made or actions approved by electronic mail or telephone.

3) By-Laws:
(a) The MCAC will establish by-laws.
(b) The MCAC by-laws, including revisions or amendments, must be approved by two-thirds of the MCAC members present for the vote.
(c) A subcommittee will review the bylaws every 2 years or as needed and make recommendations for revisions to the MCAC.
(d) Meetings shall be conducted in accordance with the by-laws established.

4) ~~Ad hoc~~ Subcommittees will be formed as needed. Subcommittee findings and recommendations will be reported to the full MCAC for their action.
Comment: Suggested edit to remove redundant language.

IV. MEMBERSHIP:

1) Membership recruitment will occur annually beginning with the appointment of a membership subcommittee on or about the ~~February~~**April** meeting of each year and completed by June of each year.

Comment: Amend par. (1) to more closely align with current practice.

2) The MCAC Vice-Chair shall chair the membership subcommittee. The subcommittee shall be responsible for developing a slate of potential members to fill anticipated vacancies on the committee as well as entering into nomination the names of MCAC members to serve as the Chair and Vice Chair for the following year.

3) Membership recruitment goals shall include recruitment of:
(a) Board-certified physicians and other representatives of the healthcare professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care.
Comment: Member recommendations for consideration and discussion:
1) Insert after physicians in (a)— "and dentists." For discussion: Should we specifically identify and reserve a seat for dentists? Should any other health care profession also be specified?
2) Replace the word "medical" with "comprehensive health care."
(b) Medicaid recipients and or family/personal representatives, consumer groups on behalf of Medicaid recipients, and members of the general public who are concerned about health service delivery to the Medicaid population.
(i) The MCAC will strive to have Medicaid recipients or personal representatives constitute one-third of its membership

(ii) Members of the following recipient groups will be actively recruited, with a preference for consumer members, to assure broad representation of Medicaid recipients:
(iii) Elders
(iv) Parents of children receiving Medicaid
(v) Recipients of TANF (Temporary Assistance to Needy Families)
(vi) Adults with disabilities, including mental illness
(vii) Family caregivers

(c) Other individuals with relevant Medicaid knowledge and background in healthcare such as, but not limited to:
(i) Acute care
(ii) Long-term care
(iii) Home care
(iv) Disabilities (including mental health)
(v) Rural health
(vi) Medicaid law and policy
(vii) Healthcare financing
(viii) Quality assurance
(ix) Patient's rights and advocacy
(x) Health planning
(xi) Social Services
(xii) Legal Services
(xiii) Problems and needs of Medicaid population
(xiv) Pharmacy care
(xv) Dental/ oral health

4) Procedure for appointment of members:
(a) An application for membership will be made available by the DHHS staff to persons interested in membership including on line, completed by the interested person and submitted to the DHHS administrative support staff for review by the membership subcommittee.
(b) In the application, prospective members will describe their interest in the Medicaid program and, if applicable, identify the agency or organization they represent and whether the organization is to be the member or the individual. If an organization is the appointed member, the head of the organization shall designate the attending member and alternate.
(c) The MCAC will establish a membership subcommittee annually in February to review applications and make recommendations for membership and nomination of officers. Members will have at least one month to consider any recommendations for membership or nominations for Chair and Vice-Chair prior to voting on them.
(d) The membership subcommittee shall make appointment and reappointment recommendations to the Medicaid Director prior to consideration by the MCAC.
(e) Appointment to the MCAC shall be made by the State Medicaid Director, upon recommendation of the MCAC, in accordance with these bylaws and federal law.
(f) Members will have a vote in all MCAC decisions only after the Medicaid Director has formally appointed them. The appointee shall be the individual, not the organization, unless clearly stated otherwise in the Medicaid Director's appointment letter.

(g) Membership shall not exceed a total of 21 members.
(h) Pre-designated alternates may attend meetings and vote in a member's stead. Alternates must complete the application and appointment process. In matters where membership status is not clearly spelled out by these bylaws and decisions are needed, the current officers will decide and inform the full membership.

5) Terms of Membership:
(a) Members shall serve terms of three years from the date of appointment, unless they resign or their membership is terminated.
(b) Meeting attendance by members and or their alternates as applicable will be documented in the minutes of each meeting. Members will be noted as attending or absent.
(c) Failure by a member to attend at least 75% of MCAC meetings in a year or three consecutive MCAC meetings in a year, without an alternate present, shall result in termination from MCAC membership.
(d) If the member is representing an organization then prior to the member being removed, the head of the organization shall be provided the opportunity to appoint another member and/or alternate to represent the organization.
(e) Members serve without compensation, except that consumer members may be provided or reimbursed for services, supports or accommodations necessary to attend and fully participate, in accordance with the "Guidelines for Reimbursement of MCAC Member Expenses."
(f) Members may not speak publicly on behalf of the MCAC without prior permission and only in accordance with a majority vote of the members present at a MCAC meeting.

V. RESPONSIBILITIES OF MEMBERS

Comment: Member recommends making this paragraph 6) in section IV.

1) Members are expected to be present at all scheduled meetings. ; Members are expected to notify the chair or staff in advance if they will be absent for any MCAC or subcommittee meeting or send their alternate. **(See comma delete first line.)**
2) Members are expected to participate in subcommittee meetings as necessary to accomplish the tasks of the subcommittee.
3) Members are expected to participate in MCAC deliberations without prejudicial bias or favoritism toward any one special interest group.
4) Members are expected to prepare in advance for MCAC meetings.
5) Members are expected to listen to the different perspectives of other members and work toward consensus on specific issues.

VI. ~~THE ROLE~~ DUTIES OF DHHS:

1) DHHS shall inform the MCAC about all changes that impact the Medicaid program, recipients or providers, including waivers, which are under consideration, within a reasonable time frame prior to and during development. **(Period added.)**

2) **DHHS shall provide information to and solicit input from the MCAC as outlined in 42 CFR § 431.12.** DHHS administrators with authority over the program areas in which changes are proposed will meet with the MCAC to explain changes, take comments and recommendations, convey these to the Commissioner and other

responsible staff prior to official action, and report back final program decisions and the basis of the decision to the MCAC. **(Comma added.)**

3) **DHHS shall provide the MCAC with the annual report on managed care in accordance with 42 CFR § 438.66(e)(3).**
Comment: To more clearly reflect and enumerate Federal policy.

4) **DHHS shall consult with the MCAC in the review of marketing materials submitted by managed care entitites in accordance with 42 CFR § 438.104(c).**
Comment: To more clearly reflect and enumerate Federal policy.

5) **DHHS shall obtain input from the MCAC on the managed care quality rating system and the quality strategy in accordance with 42 CFR §§ 438.334(c) and 438.340(c).**
Comment: To more clearly reflect and enumerate Federal policy.

6) **DHHS shall consult with the MCAC on the development and update of the access monitoring review plan in accordance with 42 CFR § 447.203(b).**
Comment: To more clearly reflect and enumerate Federal policy.

7) In the event that an urgent or time sensitive change must be made to maintain compliance with federal or state statutes or regulations, or to maintain the integrity of the Medicaid program, and time does not allow for a formal presentation at a MCAC meeting, DHHS administrators will consult with the Medicaid Director regarding communicating the change to the MCAC via email.

8) DHHS staff shall support the work of MCAC by providing administrative and technical information and assistance; however, DHHS staff will not be members of the MCAC.

9) The Medicaid Director shall serve as a liaison between MCAC and DHHS. In the event the Medicaid Director is unable to attend a meeting, the Director will assign a senior staff member of the Department to attend the meeting.

10) The Medicaid Director will make timely reports regarding Medicaid-related policy development at each meeting, and report back to the applicable program administrators all recommendations of the MCAC and requests for information.
(Removed space before "will" first line and before "applicable" on second line.)

11) DHHS staff involved with MCAC will include:
    (a) The Medicaid Director.
    (b) Professional staff assigned by the Medicaid Director, Office of Medicaid Business and Policy, from the DHHS with responsibility for development, implementation or oversight of Medicaid programs.
        (i) The assigned professional staff will:
            1. Attend the MCAC meetings, and
            2. Inform MCAC members of Medicaid-related policy developments in a timely manner.
    (c) An administrative support staff member who will assist the MCAC Chair or Vice-Chair, as needed, maintain membership and interested parties information, distribute meeting agendas and notices to the membership and

interested parties and record the minutes of the MCAC meetings, including attendance.

VII. MCAC OFFICERS:

1) The Membership Subcommittee will seek nominations for the Chair and Vice-Chair on an annual basis coinciding with membership recruitment. The Vice-Chair will not participate in the nomination process if his or her name is to be put forth in nomination for an officer position.

2) MCAC members shall elect a Chair and Vice-Chair to serve for one year. Elections will occur, at the last meeting of the fiscal year (July 1st to June 30th), in order that newly elected officers will be in place for the first meeting of the new fiscal year. There will be at least one month between nominations and elections. In the event of a vacancy in the position of Chair, the Vice-Chair will assume the responsibilities of the chair for the remainder of the term. Special elections may be held as needed.

3) The Chair and Vice-Chair may serve no more than three (3) one-year consecutive terms as officers.

VIII. Role of Chair:
Comment: Member recommends making this part of Section VII.

1. Facilitate the MCAC meetings.
2. In collaboration with the Medicaid Director, establish meeting agendas.
3. Be familiar with the MCAC by laws as well as the MCAC/DHHS Administrative Rule Procedures for reviewing proposed rules.
4. Review all official communications between MCAC and external entities such as, but not limited to the legislature, prior to release of the communications.
5. Appoint subcommittees as needed.
6. Review MCAC attendance with Medicaid Director as needed.

IX. Role of Vice-Chair:
Comment: Member recommends making this part of Section VII.

1. Assume responsibilities for the Chair if unable to be present at a meeting or unable to fulfill the term of office until a new Chair is elected.
2. Serve as Chair of the Membership Subcommittee.
3. Be familiar with the MCAC by laws as well as the MCAC/DHHS Administrative Rule Procedures.

Ratified by vote of the MCAC on ~~January~~ July 11, ~~2010~~2016
Date of Next Review: ~~November 2012~~ July 2018
Comment: Suggested by-law reordering:

I. PURPOSE
II. MEMBERSHIP
III. MCAC OFFICERS
IV. OPERATING PROCEDURES
V. DUTIES OF MEMBERS
VI. DUTIES OF DHHS

DRAFT REVISION FOR MCAC MEETING OF JULY 11, 2016

PROCESS FOR PROVIDING Medical Care Advisory Committee WITH OPPORTUNITY TO PARTICPATE IN RULE DEVELOPMENT

NOTES:

1. **All proposed amendments and comments are in blue. Amendments that are additions are underlined. Amendments that are deletions appear as a strike-through.**
2. **The text box format of the original document is changed to make it easier to work with the document. All text boxes are removed and the original text maintained.**

GOAL: In order to carry out the provisions of 42 CFR §431.12, to afford the Medical Care Advisory Committee (MCAC) with the opportunity to participate in Medicaid related rule development. The MCAC may establish subcommittees ~~**of particular interest**~~ regarding proposed rules for the purpose of making recommendations to the Department, or MCAC members may provide individual comments as representatives of their respective agencies ~~**regarding proposed rules**~~ for Department consideration. The Department encourages the MCAC and its members to participate in the Public Hearing and Public Comment Period during rule promulgation so that they may become part of the official rulemaking history.

SUBJECT RULES: He-W 500s, certain He-W 600s **and He-W 800s** regarding Medicaid financial eligibility, He-W 900 SCHIP, certain He-C's, He-E's, and He-M's with Medicaid service, waiver, eligibility, or ratesetting components, and any other rule located in another chapter that has Medicaid components.

STEP 1. The Department develops and reviews a proposed draft of a rule. This may or may not include initial stakeholder input.

STEP 2. The Department Division Director, or designee, reviews the rule.

STEP 3. The Department sends the proposed rule and rule summary to the MCAC via email at least 2 weeks prior to the MCAC meeting described in **STEP 4**.

For rules that are to be readopted and include no substantive legal or policy changes, where the Department expects no questions, discussion, or objection, the Department will indicate in its summary of the rule to the MCAC, that the rule will be placed on a "consent" agenda, unless requested otherwise by a committee member within one week of rule submission. Under this model, any rule on a consent agenda will not have a formal presentation at a MCAC meeting unless explicitly requested by a MCAC member before the meeting.

In the event that the Department does not send a rule to the MCAC at least 2 weeks prior to the meeting in STEP 4, the rule will not be placed on a consent agenda unless the Chair of the MCAC, at the request of the Department and after consultation with members, so directs. The rule may not be placed on the consent agenda if the rule is not sent to the MCAC at least 3 business days prior to the meeting.

STEP 4. The Department presents the proposed rule to the MCAC at least 3 months/meetings prior to the anticipated FIS filing deadline, subject to certain exceptions.*

The MCAC may ~~**choose to**~~ empanel a subcommittee at the meeting, if desired.

*The 3 month/meeting timeframe is best suited to new rules, readoptions, and amendments. In the event the Department must adopt rules more quickly, including the adoption of interim rules necessary to implement changes in the law, the Department will move through this process in an abbreviated fashion.

DRAFT REVISION FOR MCAC MEETING OF JULY 11, 2016

STEP 5A. If a **subcommittee is empanelled,** members will be appointed and meetings scheduled with Department representatives, as appropriate. The subcommittee will provide their comments and/or recommendations to the Department no later than 30 days following the meeting at which the Department presented the rule.* **In the event the Department does not send the rule to the MCAC at least 2 weeks before the meeting in which the rule is presented, the 30-day time frame for submission of comments will be extended by the number of days in the 2-week period the MCAC did not and should have had the rule prior to the meeting.**

*Exceptions to this timeframe will be considered on a case-by-case basis.

STEP 5B. If **no subcommittee is empanelled**:

- If one or more members recommend that the MCAC submit preliminary comments on the rule, and a majority of the membership present agrees, a representative of that membership will draft a letter for the Chair. The chair will review the letter to ensure that the letter reflects the MCAC's discussion and sign, if appropriate. The Chair will submit the letter within 10 business days of the MCAC meeting at which the Department presented the rule.
- Individual MCAC members who wish to provide comment to the Department for consideration prior to the FIS filing, may do so within 10 business days and as representatives of their own respective organizations.
- **In the event the Department does not send the rule to the MCAC at least 2 weeks before the meeting in which the rule is presented, the 10 business-day time frame for submission of preliminary or individual member comments will be extended by the number of days the MCAC did not have and should have had the rule prior to the meeting.**

[Proceed to Step 9.]

STEP 6. The Department considers the MCAC subcommittee and member comments, and makes changes to the rule, if any.

STEP 7. The Department sends **a written response to the MCAC comments,** the rule, and rule summary to MCAC members at least 2 weeks before the MCAC meeting immediately prior to the anticipated FIS filing deadline.

The rule is scheduled as a discussion item at that meeting.

STEP 8. If one or more members recommend that the MCAC submit a position on the rule, and a majority of the membership present agrees, a representative of that membership will draft a letter for the Chair. The chair will review the letter to ensure that the letter reflects the MCAC's discussion and sign, if appropriate.

Individual MCAC members who wish to submit a position on the rule to the Department, may do so as representatives of their own respective organizations.

NH Medicaid Care Management: CMS Final Rule (CMS-2390-F)

July 2016

Agenda

- Background and goals of final rule
- Implementation dates
- Beneficiary experience
- Network Adequacy and Access to care
- Short term IMD stays
- Quality
- Program Integrity
- Payments

Background

Background and goals of final rule

- On June 1, 2015, CMS issued a notice of proposed rulemaking to modernize the regulatory framework for Medicaid managed care and create alignment with other insurance programs where appropriate.
- CMS published the final rules on May 6, 2016 with an effective date of July 5, 2016.
- Goals:
  - To strengthen beneficiary experience of care and key beneficiary protections.
  - To support State efforts to advance delivery system reform and improve quality of care.
  - To strengthen program integrity by improving accountability and transparency.
  - To align key Medicaid managed care requirements with other health coverage programs.

Implementation Dates

Implementation Dates

On April 25, 2016, CMS issued a document that outlines the Implementation dates for the various provisions of the new rule. These dates range from May 6, 2016 to July 1, 2019.

- Effective immediately: Federal financial participation for external quality review. §433.15 and §438.370.
- Effective 60 days after publication (July 5, 2016), for example:
  - State fair hearing provisions §431.220, §431.244
  - Choice of network provider standards §438.3(l)
  - Parity in mental health and substance use disorder benefits §438.3(n)
- Effective no later than rating period for contracts starting on or after 7/1/2017, for example:
  - Inspection and audits §438.3
  - Actuarial soundness §438.4
  - Rate development §438.5
  - Medical loss ratio §438.8

Implementation Dates

- Effective no later than rating period for contracts starting on or after July 1, 2018, for example:
  - Ability to increase or decrease capitation rate by 1.5% without rate certification §438.4
  - Network adequacy standards §438.68
  - Enrollee encounter data §438.818
- Effective no later than July 1, 2018:
  - Managed care quality strategy §438.340
- Effective after CMS guidance:
  - Annual program report §438.66
  - Medicaid managed care quality rating system §438.334

Beneficiary Experience

Beneficiary Experience- Information requirements

- States to operate a website to provide specific managed care information including each managed care plan's handbook, provider directory, and formulary.
- States to develop definitions for key terms and model handbook and notice templates for use by the managed care plans.
- Enrollee information must be accessible to people with disabilities and available in locally prevalent non-English languages.
- States and managed care plans may provide required information electronically and in paper format upon request and free of charge.

Beneficiary Experience- information requirements

- NH DHHS already approves the model handbook and notice templates for use by the managed care plans.
- Enrollee information is currently accessible to people with disabilities and available in locally prevalent non-English languages.
- NH DHHS will be working with the Managed care organizations (MCOs) to confirm that enrollee materials are available in both electronic and paper format when requested, free of charge, and will make the appropriate contract changes to ensure MCO compliance.
- NH DHHS will verify that each MCO has their provider directories and formularies available on each plan's website.

Beneficiary Experience- enrollment and disenrollment

- States must establish an independent beneficiary support system that offers choice counseling and information to all enrollees and assistance to enrollees who use long-term services and supports.
- States required to provide notices to explain implications of enrollees' choices as well as disenrollment opportunities.
- NH DHHS currently contracts with Maximus to provide choice counseling and the Department will be reviewing the contract scope to add enrollment in-person functions and to increase choice counseling functions.
- Currently, under NH Medicaid, when a prospective enrollee become eligible for Medicaid, notification is sent out to the individual. NH DHHS will review the current notifications to ensure that they adequately inform individuals of their choices and disenrollment opportunities.

Beneficiary Experience- managed long-term services and supports (MLTSS)

- States must establish and maintain a structure for stakeholder engagement in planning and oversight of MLTSS programs.
- Enrollees with LTSS needs must be involved in person-centered treatment and service planning.
- The rule creates for cause disenrollment reason to another plan if institutional, employment, or residential provider leaves enrollee's plan.
- States must have transition plans when a beneficiary moves from FFS to managed care or into a new managed care plan.
- Senate Bill 553, 2015, establishes a robust process for stakeholder engagement and the development of a comprehensive plan to transition MLTSS and other waiver services into managed care. NH DHHS will ensure that the new for cause disenrollment and the transition plan requirements are incorporated into the next managed care contract.

Network Adequacy and Access to Care

Network adequacy and Access to Care

- States to develop and implement time and distance standards for primary and specialty care (adult and pediatric), behavioral health, OB/GYN, hospital, pharmacy and pediatric dental services.
- State to develop and implement network adequacy standards for MLTSS programs, including providers that travel to the enrollee.
- The final rule requires external quality reviewers to validate network adequacy and improves the transparency of quality information.
- Managed care plans must certify network adequacy at least annually.
- NH DHHS will review its contract with the EQRO to determine whether the scope of the contract needs to be amended to account for increased network adequacy review activities.
- NH DHHS will add time and distance standards for OBGYN and pediatric specialists to the managed care contract.

Short Term IMD Stays

Short Term IMD stays

- The final rule permits the state to make a monthly capitation payment to the managed care plan for an enrollee, aged 21-65, that has a short term stay in an Institution of Mental Disease (IMD):
  - Short term stay is a stay no longer than 15 days within a month.
- "In lieu of services" (ILOS) are medically appropriate and cost effective alternatives to state plan services or settings. The final rule establishes contractual and rate setting requirements for ILOS.
- The Department will amend the MCO contract to permit short term stays at an IMD and clarify that a stay can be up to 30 days if the stay occurs over two months.

Quality

Quality

- The final rule requires states to implement a quality rating system (QRS) for managed care plans and to report plan performance.
- CMS expects to implements the QRS over 5 years.
- States may use the QRS CMS proposes or adopt an alternative with CMS approval.

- Currently, NH Medicaid's transition of care policy addresses care between FFS to MCO and MCO to MCO, and DHHS will be including transition of care policies into the comprehensive quality strategy.

- NH DHHS will develop a comprehensive quality strategy as a living document across all Medicaid programs.

- NH DHHS will participate in the comment period for the QRS CMS proposes and will determine whether to rely on the proposed QRS or develop its own.

Program Integrity

Program Integrity

- Requires managed care plans to implement and maintain administrative and managerial procedures to prevent fraud, waste and abuse.
- States must screen and enroll all managed care network providers who are not already enrolled in the state's FFS system.
- Requires managed care contracts to address treatment of recovered overpayments and to take these into account in the rate setting process.
- NH DHHS will analyze its current processes around reviewing MCO subcontractor agreements and provider enrollment to determine whether any changes need to be made to the current enrollment process.

Payments

Payment and accountability: actuarially sound capitation rates

- Establishes standards for documentation and transparency of the rate setting process to facilitate federal review and approval of the rate certification.
- Permits states to increase/decrease the capitation rate by 1.5% without submission of a new rate certification.
- Permits mid-contract year rate changes due to the application of approved risk adjustment methodologies without additional contract and rate certification approval.
- NH DHHS will build in the new documentation review standards into the managed care contract and review process.

Payment: Medical loss ratio (MLR) Standard

- The final rule requires managed care plans to calculate and report their MLR experience for each contract year.
- Actuarially sound rates are set to achieve a MLR of at least 85%.
- States may set a higher standard or impose a remittance requirement.
- NH DHHS will work with its actuary, Milliman, to determine whether the MCOs are meeting the 85% MLR standard and whether a higher standard is needed.

Payment and delivery system reform

- The final rule provides flexibility for state to have value-based purchasing models, delivery system reform initiatives, or provider reimbursement requirement in the managed care contract.
- The final rule strengthens existing quality improvement approaches.
- Permits states to set min/max network provider reimbursement levels for network providers that provide a particular service.
- Currently the contract with the MCOs require that DHHS will withhold one percent of the MCO capitation payments in each year under the payment reform plan. DHHS will review the payment reform plan and the flexibility provided by the CMS regulations to determine whether any changes will be made.

Conclusion

NH DHHS is reviewing each section of the final rule and the CMS comments to determine the extent of changes needed to the managed care program and the current managed care contract. Additionally, DHHS is assembling a team of subject matter experts to determine actions needed for immediate compliance and will develop a timeline for actions needed as each provision of the rules becomes effective.